Michigan Medicaid Hospice Providers

Billing Information & Reference

Scope/Coverage Codes

- Common Scope Codes
  - 1 – Medicaid
  - 2 – Medicaid
  - 3 – Adult Benefits Waiver
  - 4 – Refugees and Repatriates
- Common Coverage Codes
  - 0 – No Medicaid eligibility/coverage
  - E – Emergency/Urgent Medicaid Coverage Only
  - F – Full Medicaid Coverage
  - G – Adult Benefits Waiver
  - Y– Family Planning Waiver

Medicaid Website

www.michigan.gov/mdch


MDCH
Department of
Community Health
Michigan.gov
An Official State of Michigan Web Site
Michigan.gov Home
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Search
GO
Advanced Search
Birth, Death, Marriage & Divorce Records
Physical Health & Prevention
Pregnant Women, Children & Families
Mental Health & Substance Abuse
Health Care Coverage
Statistics & Reports
Providers
Inside Community Health
Health Systems & Health Profession Licensing
Homeland Security
michigan steps up
michiganstepsup.org
Safe Delivery of Newborns
MICHIGAN Mental Health Commission
CLICK FOR MORE INFO
Tax Time Resources
[Printer Friendly]
[Text Version]
A A
What's New
From the Director
Director Janet Olszewski details the steps Michigan is taking to address the potential threat of pandemic influenza.
MDCH Announces Launch Of Michigan Volunteer Registry
Web-based System Raises Level Of Protection For Michigan Citizens
Department to Host Statewide Long Term Care Conference
Where to find information about Medicare Part D Pharmacy Plans
Helpful contact information for beneficiaries and providers
Request for Proposal for Long-Term Care Single Points of Entry PDF
Long-Term Care Single Points of Entry.
Response to Questions Submitted
About our Organization
Meet the Director
Janet Olszewski is Director of the Michigan Department of Community Health (MDCH). The department is responsible for health policy and management of Michigan's publicly funded health systems. Services are planned and delivered through several integrated components.
About the Michigan Department of Community Health
The Michigan Department of Community Health (MDCH) is one of 22 departments of state government.
The department, the largest in state government, is responsible for health policy and management of the state's publicly-funded health service systems. An estimated 1.5 million Michigan residents will ...
Departments & Agencies
State Sponsored Sites
Online Services
Quick Links
Influenza in Michigan
Michigan Medicaid Long Term Care Task Force
Informed Consent for Abortion
Shortcuts to MDCH Web Topics
MDCH Brochures Available for Download
Emerging Diseases
Might I be eligible for benefits? Click here to find out
Local Health Department Map
GENDIS - Genealogical Data
Aging Services - MiSeniors.net
News Releases
Michigan's State Planning Project for the Uninsured.
Community Collaboratives
MDCH Online Services
MiRx Prescription Savings Program
Health Professions Licensing & Regulation

Providers
- HIPAA
- Health Professional Shortage Area
- Institutional Review Board
- State Loan Repayment Program
- Lab Services
- Public Health Preparedness
- Communicable & Chronic Diseases
- Departmental Forms
- Community Mental Health Services
- Certificate of Need
- Toxic Substances
- Substance Abuse Providers

Birth, Death, Marriage and Divorce Records
Physical Health & Prevention
Pregnant Women, Children & Families
Mental Health & Substance Abuse
Health Care Coverage
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Health Systems & Health Profession Licensing

PROVIDERS

MDCH administers many healthcare programs. Using the links below, providers can access policies, communications, billing, reimbursement, and training information, forms, etc. specific to each program.

For additional assistance providers may contact Provider Support at 1-800-292-2550 or ProviderSupport@michigan.gov.

HOT TOPICS

- CHAMPS

Medicaid is a federal and state funded health care program that provides comprehensive health care coverage for the medically indigent.

Information about **Mental Health & Substance Abuse**

Information about **Children's Special Health Care Services**

Other Health Care Programs includes Adult Benefits Waiver, Healthy Kids Dental, MI Choice,

Provider Enrollment
Access provider enrollment forms and information, as well as instructions for initiating Electronic Funds Transfers (EFT)

Eligibility Verification System
Access information and options available related to verfying beneficiary eligibility.

Draft Policy Bulletins for

Providers

- HIPAA
- Health Professional Shortage Area
- Institutional Review Board
- State Loan Repayment Program
- Lab Services
- Public Health Preparedness
- Communicable & Chronic Diseases
- Departmental Forms
- Community Mental Health Services
- Certificate of Need
- Toxic Substances
- Substance Abuse Providers

Birth, Death, Marriage and Divorce Records

Physical Health & Prevention

Pregnant Women, Children & Families

Mental Health & Substance Abuse

Health Care Coverage

Statistics and Reports

Inside Community Health

Health Systems & Health Profession Licensing

MEDICAID

Medicaid is a federal and state funded health care program that provides comprehensive health care coverage for the medically indigent. This page supplies coverage, billing and reimbursement policies and other important information for enrolled providers. Much of the information provided also applies to other heath care programs administered by MDCH (e.g., Adult Benefits Waiver, MOMS, Plan First!, Children's Special Health Care Services, etc.)

For questions related to the content of the Medicaid Provider pages, please email MSAPolicy@michigan.gov .

HOT TOPICS

- CHAMPS
- Biller "B" Aware
- Provider Tips
- Documentation EZ Link

Get information about **Policy and Forms** like the Medicaid Provider Manual, draft and final policy bulletin, etc.

In **Billing and Reimbursement**, find information necessary for claim submission, including billing tips, provider-specific

Provider Enrollment
Access provider enrollment forms and information, as well as instructions for initiating Electronic Funds Transfers (EFT)

Medicaid Billing & Reimbursement

Provider Updates

- Biller “B”Aware
  - Current Medicaid issues (RAM Notices)
- Newsflash
  - Important upcoming dates
- Provider Inquirer Newsletter
- Medicare Crossover Information
- Provider Tips
  - Tips for specific provider groups

Provider Enrollment /CHAMPS

- Contact Information:
  - Champs Hotline #1-888-643-2408 to assist providers with enrollment on Champs website if necessary
  - Phone 1-517-335-5492
  - Fax: 1-517-241-8233
  - E-Mail: ProviderEnrollment@michigan.gov
  - P.O. Box 30238
Lansing, MI 48909
  - Champs Hotline # 1-888-643-2408
- Provider ID will be disenrolled if mail is returned
- Report changes in Provider ID on CHAMPS
  - Tax ID, Address, Specialty, Services, etc.
- Electronic Funds Transfer (EFT)
www.migov/cpexpress or ph# 1-888-734-9749

Medicaid Online Manual

- Viewable in Adobe Acrobat Reader
  - Version 5.0 or higher
- Updated Quarterly on Website
  - New quarterly information highlighted
- New CD’s are only sent yearly
- Directory Appendix

Medicaid Policy Bulletins and Proposed Changes

- All Bulletins posted online
- Posted by Issue Date
- Proposed Policy Bulletins posted
  - 30 day Public Comment Period
  - Request form available to Participate in Policy Proposal Review

Provider Specific Information Revenue codes to use

- **0651** Routine Home Care I (Less than 8 hours of care not necessarily consecutive, in a 24-hour period)
- **0652** Continuous Home Care (8 hours or more of care not necessarily consecutive, in a 24-hour period)
- **0655** Inpatient Respite Care
- **0656** General Inpatient Care
- **0657** Physician Services
- **0658** Other Hospice I (to bill Room & Board when Patient is in a nursing home or licensed hospice long-term care unit.)

Hospice Specific information (continued)

- **0185** Hospital Leave Days (must not exceed 10 consecutive days)
- **0183** Therapeutic Leave Days (must not exceed 18 total days for the year)

Admission date: include the admission date for hospice care

Inpatient Respite Care: "Occurrence Span Code"- include occurrence span code M2 and complete the "from and through" dated for an episode of inpatient respite care.

Core Based Statistical Area (CBSA): "Value codes" – include value code 61 in value code field. Additionally, report the CBSA number followed by two zeros.

Patient –Pay Amount

Use value code D3 and the dollar amount to reflect the patient pay amount to be applied to the claim.

Hospices must bill Medicaid even if the patient-pay amount is greater than the amount billed to Medicaid. Medicaid requires that a claim be billed so it can obtain particular information off the claim for statistical purposes.

Hospice Membership Notice (DCH-1074)

DCH-1074 must be completed

- when a beneficiary needs Hospice care
- when a hospice-enrolled beneficiary dies (indicating the date the beneficiary expired)
- when the beneficiary moves too far for the hospice to continue service and must arrange a transfer of care to another Medicaid enrolled hospice.
- If a Nursing Facility contracts to make hospice services available, the hospice must provide DCH-1074 forms to Medicaid, Medicare and dually eligible beneficiaries.

Fax to MDCH Enrollment Services Section Fax # 517-373-1437

A copy must be retained in the beneficiary's record, given to the beneficiary or his legally appointed representative

Explanation Codes

- MDCH has their own list of edit codes on our website
- Identifies status of claim
  - Paid
  - Pend
  - Reject
- Informational Edits
  - Appear with an “X” after the edit

Hospice billing errors

- Edit 100 The claim pends with this edit if the room rate is not on file for the date being billed.

If this occurs check the following:

Check Medicaid eligibility record authorization for each patient. If the authorization is the legacy ID# of your Hospice Company this is an error and is causing your claim to pend.

Obtain the LTC Nursing Facility's legacy ID# for the date span the patient lived there. The facility should give you that information.

Edit 100 continued

- Fill out a new MSA-1074 with correct LTC Nursing Facility's legacy ID# . Provider Enrollment is required to supply the legacy ID# in this situation. Fax it to (517) 373-1437
- If there is no rate loaded under the LTC Nursing Facility's legacy ID# for the date span the patient lived there it will also set the edit 100.
- Check our website for provider specific information to determine if a rate has properly been loaded.
- If there is no rate for the date span you are billing for then contact the LTC Nursing Facility and ask them to contact the rate settlement area for correction.

158 Edit (billing limitation)

- The claim was received by MDCH more than one year after the date of service (DOS)
- Resolution-
  - Medicaid Manual
    - General Information for Providers, Section 10.3
  - Claims must be submitted and acknowledged by MDCH within 365 days from DOS.
  - For any claim submitted after 365 days, there MUST be prior activity within the last 120 days.

Hocpice billing errors

- Edit 970 Recipient Level of Care is not equal to 16 on Hospice invoice for each date of service.

Check to see if a DCH-1074 was ever completed to inform DCH that this patient is now receiving Hospice care for the dates of service being billed.

158 Edit (billing limitation)

- Example:
  - DOS = 3/1/04
  - Claim submitted on 1/28/05
  - Claim received by MDCH 2/1/05
  - Claim rejected by DCH on 2/12/05
  - If the claim is not submitted and acknowledged again before 3/1/05, which is the 365 day limit, the claim must be submitted and acknowledged within 120 days from 2/12/05 to keep the claim active.

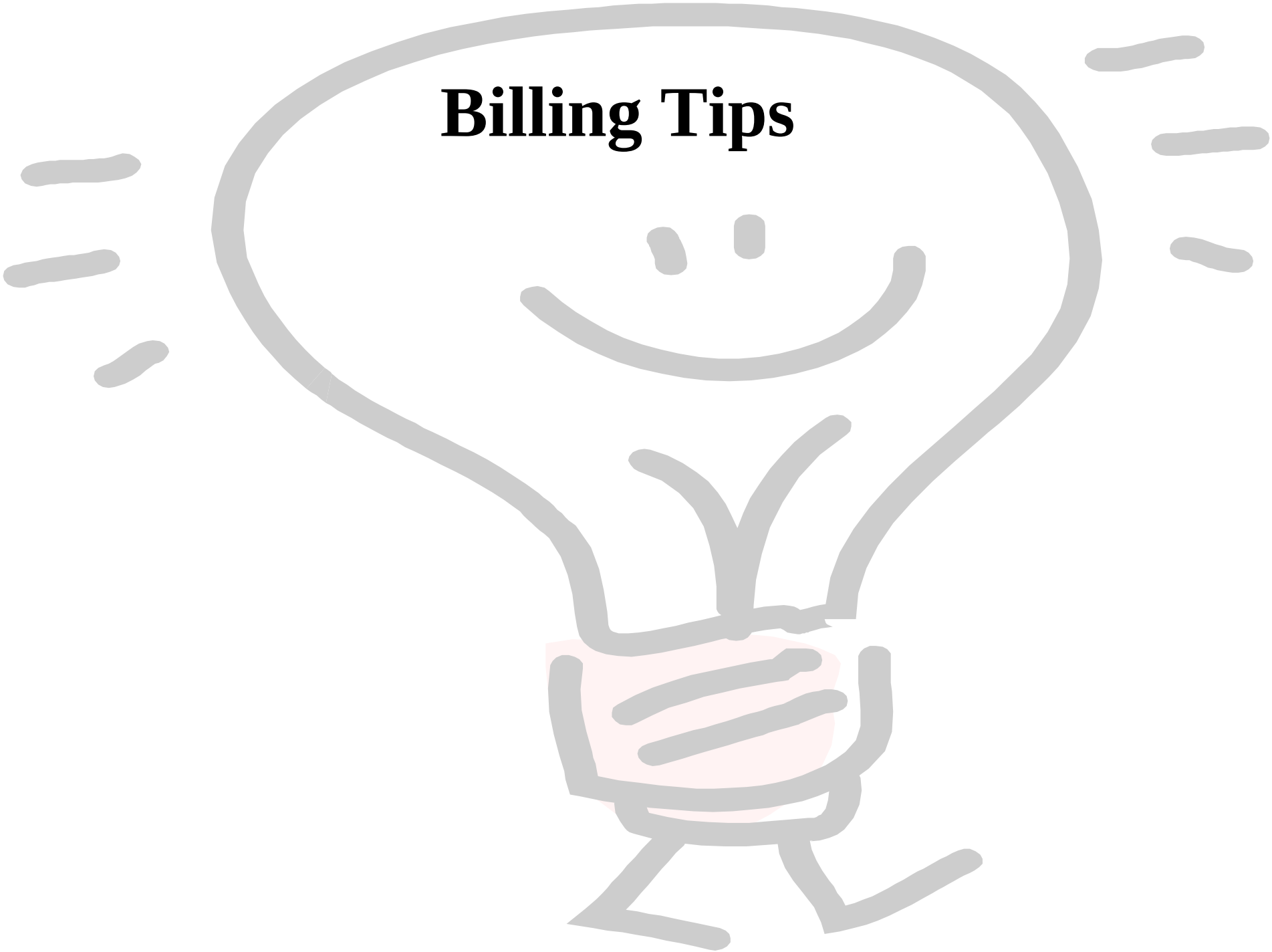
Day Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	- -	88	119	149	180	210	241	272	302	333	363
30	30	- -	89	120	150	181	211	242	273	303	334	364
31	31	- -	90	- - -	151	- - -	212	243	- - -	304	- - -	365

Example: 120 Days
6100-6220

Edit 158 (billing limitation)

- Continue tracking rejections back until either a CRN indicates receipt by MDCH prior to one year from the DOS or a gap of more than 120 days is found.
- If Medicare paid your claim late MDCH will use the Medicare payment date as an exception. The exception is that Medicaid must be billed within 120 days of Medicare's payment. Report the date of Medicare EOB in the remarks section of the claim.

Billing Tips



Billing Tips

- To remove other insurance from Third Party Liability (TPL) file:
  - Phone 800-292-2550 (option 4)
  - Fax 517-346-9817
  - TPL_Health@michigan.gov

Replacement/Void Claim Tips

- Only approved claims can be replaced or void/canceled. If the approved amount on any line of a claim states anything other than PEND or REJ, then the claim is considered approved.
- Do not submit replacement or void/cancel claim when the entire claim rejected. If the claim is rejected, re-submit the entire claim.
- Be sure when claim replacing or voiding to use the **MOST RECENT APPROVED CRN**! Claim remarks are always required to explain why the claim is being replaced or void/canceled.

Replacement Claims

- Correct Claim Completion instructions apply.
- Replacement claim MUST have same Beneficiary ID and Provider ID of original claim.
- Resubmit claim in its entirety in the manner it should have been submitted originally.
  - Replacement claim will completely replace original claim.
- Use a Claim Replacement Code of “7”.
  - All Electronic Billing: Known as “Claim Frequency Type Code”.
  - UB-04: Known as “Type of Bill, Frequency Code” the last digit will be a 7 in the type of bill . Example: 217, 227, 237 etc.

Replacement Claims

- Submit a replacement claim when:
  - All or part of a claim was paid incorrectly.
  - All or part of a claim was billed incorrectly.
    - i.e. Incorrect Units, Charges, Procedure Code, Date of Service, etc.
- Always use the CRN from the last approved claim when replacing or void/canceling a claim.

Void/Cancel Claims

- Correct Claim Completion instructions apply.
- Void/Cancel claim MUST have same Beneficiary ID and Provider ID of original claim.
- Complete one service line with $0.00 billed.
  - Entire original payment will be debited.
- Use a Claim Replacement Code of “8”.
  - Electronic Billing: Known as “Claim Frequency Type Code”.
  - UB-04: Known as “Type of Bill; Frequency Code” the last digit will be a 8 Example: 218, 228, 238 etc.

Void/Cancel Claims

- Submit a Void/Cancel Claim when:
  - A claim is paid under the wrong provider ID or beneficiary ID.
    - If claim was billed under the wrong provider ID or beneficiary, the same provider ID and beneficiary ID must be used on the void claim. A new claim can be submitted for the correct provider ID/beneficiary ID.
  - The claim was never meant to be submitted.
  - A duplicate claim has paid.
- Always use the CRN from the last approved claim when replacing or void/canceling a claim.

Medicare Buy-In Unit (MDCH)

- The Medicare Buy-In Unit is responsible for:
  - Processing Medicare premium payments for eligible Medicaid beneficiaries.
  - Other Insurance (OI) Coding for Medicare on the Medicaid system.
  - Alien information for Medicaid beneficiaries that are age 65 or over, must have the date of entry forwarded to the Buy-In Unit if the beneficiary has not been in the US for over 5 consecutive years.

Medicare Buy-In Unit

- This is a Resource **for Providers Only**.
- Buy-In determines if MDCH can pay Medicare premium amounts for beneficiaries that cannot afford the payments.
- Beneficiary must have a Medicaid ID and be enrolled with Medicare for the Buy-In Unit to do analysis.
  - Phone: 1-517-335-5488
  - Fax: 1-517-335-0478
  - Email: BuyInUnit@michigan.gov (preferred)
- The Medicare Buy-In Unit is not able to address questions directly from beneficiaries. Beneficiaries should contact their caseworker or the Beneficiary Help Line (1-800-642-3195) with questions.

Medicare Buy-In Unit

- Contact the MDCH Buy-In Unit if the Medicare eligibility information given by MDCH does not match the Medicare eligibility information given by Medicare, **and** the beneficiary
  - A) has enrolled with Medicare before[1], or
  - B) is a legal alien over 65 who has not been in the country for more than 5 years[2].

[1] A beneficiary cannot "Buy-In" through MDCH unless they are enrolled with Medicare.

[2] Aliens cannot enroll in Medicare or Buy-In through MDCH unless they are legal aliens and have been in the country for 5 consecutive years.

QUESTIONS?